471-000-9 Form DM-12D, "Social Study" and Completion Instructions

Use: Local office staff complete Form DM-12D to submit information to the State Review Team (SRT) for -

1. AABD/MA or SDP/MA cases when an initial or a continuation review for disability/blindness is needed by the SRT;
2. ADC-I/MA (Incapacitated Parent) cases or Employment First Exemptions when an initial or a continuation review for incapacity is needed by the SRT;
3. Working Disabled cases when an initial or continuation review for working disabled is needed by the SRT;
4. Emergency Medical Services for Aliens cases when a determination is needed by the SRT. (Please indicate under which category of Medicaid eligibility the applicant would be reviewed if s/he were a US citizen; e.g., ADC, ADC-I, AABD, CMAP); or
5. Cooling Assistance cases when a medical need determination is needed by the SRT.

Number Prepared: Form DM-12D is completed in duplicate.

Completion: The local office worker completes Form DM-12D. In the upper left hand corner, check the box(es) which indicates under which program(s) the SRT is reviewing the case.

1. Enter the client's name and address.
2. Enter the client's Social Security number, date of birth, sex, and marital status.
3. Enter the name of the local office worker submitting the form, the local office name, and the date the form is completed.
4. Enter the original date of request for assistance, the medical effective date requested for the current SRT review, and the client's current living arrangement.
5. Circle the highest grade level completed. Check the box marked "Prior Vocational Training" if the client has received any type of vocational/technical training and specify the type of skill trained for on the line provided. If the alleged disability/incapacity may be related to mental retardation, list the client's I.Q. as established by psychological or psychiatric tests or obtain copies of I.Q. evaluation/report and submit with medical information.
6. Enter the date the client last worked. List the client's work history in reverse chronological order, last employment first.
7. Enter the current RSDI status. Also check any other source of support currently being received by the client.
8. Enter the date the client last applied for SSI and check the status of the application. If the client was not referred to SSI, check this box and specify the reason a referral was not made.
9. List the date(s) (from/to), place, and reason for both inpatient and outpatient medical/psychiatric evaluation and treatment.
10. The worker asks the client questions 10A through 10G and enters his/her response.

11. The local office worker completes this section based on knowledge or observation of the client's situation.
    11A. Record personal observations or mark “did not see the client”.
    11B. Record information on earned income *for all persons*, including the working disabled applicants, who are or have worked during any period of time for which eligibility is being requested.
    11C. Include any information that the worker believes the SRT should know for purposes of this review and that has not been included anywhere else on the Form DM-12D. In addition, for AABD/MA or SDP/MA cases, include a statement that clearly establishes the basis for the referral to the SRT. For example,
        a. Denial by SSI based on duration; or
        b. Disability determination needed for month(s) prior to month of SSI approval;

        <u>For direct referrals to the SRT based on 469 NAC 2-007.03B 1-5</u>:
        c. Excess income or resources for SSI;
        d. The applicant requires immediate long term hospitalization and/or treatment for a severe impairment before SSI can make a determination;
        e. Institutionalization;
        f. Death; or
        g. The applicant is a non-US citizen who cannot be reviewed by SSI.

<u>Distribution</u>: The original Form DM-12D is submitted to the HHS Finance and Support, Medicaid Division, State Review Team with the required Form DM-5 and medical reports; a copy is filed in the case record.

<u>Retention</u>: Form DM-12D is retained in the case record for four years.

To view printable form click here: Social Study (Disability/Incapacity Determination)

- ☐ AABD/MA (State/Fed) or SDP/MA (State)
- ☐ ADC - I/MA (State/Fed), EF Exempt
- ☐ Working Disabled, Illegal Alien
- ☐ Cooling

Nebraska Department of Health and Human Services
SOCIAL STUDY
(Disability/Incapacity Determination)

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
DEPARTMENT OF SERVICES · DEPARTMENT OF REGULATION AND LICENSURE · DEPARTMENT OF FINANCE AND SUPPORT

1. Name of Client	Address		
2. Social Security Number	Birthdate	Sex	Marital Status
3. Worker Completing Form	Local office	Date Completed	
4. Original Date of Request	Medical Effective Date Requested	Living Arrangements	

5. Literacy and Education

Circle Last Grade Completed:
0 1 2 3 4 5 6 7 8 9 10 11 12

College: 1 2 3 4

Prior Vocational Training: ☐ Yes
Skill Trained For:_____

If Mentally Retarded, Give I.Q.:
_____

6. Employment (Last Job First) Date Last Worked:

From Month, Year	To Month, Year	Description

7. Current Source of Support

RSDI
- ☐ Pending
- ☐ Approved
  - ☐ Aged
  - ☐ Disabled
  - ☐ Dependent
- ☐ Denied:
  - ☐ Duration
  - ☐ Severity
  - ☐ Not Insured

- ☐ VA
- ☐ Unemploy. Benefits
- ☐ ADC
- ☐ Gen. Assist
- ☐ Retirement Pension
- ☐ Family
- ☐ Workmen's Comp.
- ☐ Other _____

8. Current Status: SSI

Date Last Applied:
_____

- ☐ Pending
- ☐ Approved
  - ☐ Denied:
  - ☐ Duration
  - ☐ Severity
  - ☐ Excess Income
  - ☐ Excess Resources
- ☐ In Appeal
- ☐ Not Referred:

Reason:_____

9. Medical/Psychiatric Care (most current first)

INPATIENT

Date	Where	Reason

OUTPATIENT

Date	Where	Reason

SPECIAL NOTE TO WORKER COMPLETING THIS FORM:

It is important to remember that the State Review Team has had no opportunity to see or talk with the client personally and must depend upon the written information provided by you and the physician.

TO BE COMPLETED BY THE CLIENT WITH THE WORKER

10 A. What are your symptoms, and what is the nature of your disability/incapacity?

10 B. When did your disability/incapacity start?

10 C. How long will it last?

10 D. How are you limited in your activities at work?

10 E. Who are all the primary and consulting physicians involved in the care of your condition/s for at least the last 18 months? (Name and Specialty)

10 F. Do you think you will be able to return to your previous line of work? Why?

10 G. What special circumstances, in addition to the above, do you want the State Review Team to know about yourself?

TO BE COMPLETED BY THE CLIENT WITH THE WORKER

11 A. Please describe the client's physical appearance, difficulty in restriction of motion or ability to walk, stand, or sit, bend, lift, push, reach, carry, hear, see, understand or speak.

11 B. Working disabled information.

Earning/Gross_____ Hours Working_____ Job Type_____

11 C. Please include a brief social history of any information that you feel the State Review Team should know in reviewing this case that has not been brought out already (e.g., other conditions or problems).